DAVIS SCHOOL DISTRICT
HOMEBOUND/HOSPITALIZED SERVICES
REFERRAL REQUEST

STUDENT: _____
LAST FIRST INITIAL

SCHOOL: _____

GRADE: ____ MALE_____ FEMALE_____

ADDRESS: _____
NUMBER AND STREET

STUDENT NUMBER_____

DATE OF BIRTH_____

_____
CITY STATE ZIP CODE

HOME PHONE_____

BUSINESS PHONE_____

PARENT / GUARDIAN _____

_____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

STATEMENT OF HEALTH PROFESSIONAL

This statement to be completed by the Licensed Physician, Licensed Psychologist, or Licensed Social Worker providing treatment and verification of the condition requiring the absence from school. USE BACK OF FORM IF NECESSARY.

DIAGNOSTIC STATEMENT: _____ DATE OF EXAMINATION: _____

REASON FOR STUDENT'S INABILITY TO ATTEND SCHOOL: _____

ESTIMATED TIME STUDENT WILL REQUIRE EDUCATIONAL SERVICES: _____
Beginning Date _____ Estimated Returning Date _____

LOCATION OF EDUCATIONAL SERVICES, IF NOT AT HOME:_____

CAN STUDENT ATTEND SCHOOL PART-TIME? **NO ☐ YES ☐APPROXIMATE # OF HOURS CAN ATTEND SCHOOL** _____

INDICATE LIMITATIONS IN THE PROVISION OF EDUCATIONAL SERVICES (and risk of contagion, if applicable)

ADDRESS OF HEALTH PROFESSIONAL: _____

Please Print: Name STREET ADDRESS CITY ZIP

SIGNATURE OF PHYSICIAN OR HEALTH PROFESSIONAL DATE

_____

---

*SPECIAL

EDUCATION SERVICES CURRENTLY? NO_____ YES _____ I.E.P. EXPIRATION DATE_____

*SPECIAL EDUCATION SERVICES IN THE PAST? NO_____ YES _____ DATES_____ *This includes resource services.

DESCRIBE
SERVICES_____

School Administrator Authorization

_____
Teacher Assigned

_____ _____
School Administrator Signature Date

SCHOOL DISTRICT AUTHORIZATION

Approved _____ Denied _____

Reason _____

_____ _____
Student Services Administrator Signature Date

The purpose of this placement is to lend temporary education support to students experiencing health problems.

Revised 10/05